State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495360	A. BUILDING _____ B. WING _____	07/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WOODLANDS HEALTH AND REHAB CENTER	1000 FAIRVIEW HEIGHTS CLIFTON FORGE, VA 24422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 000	Initial Comments	F 000		

An unannounced biennial State licensure inspection was conducted 07/14/2015 through 07/16/2015. Corrections are required for compliance with Virginia Rules and Regulations for the Licensure of Nursing Facilities. No complaints were investigated during the survey.

The census in this 60 certified bed facility was 57 at the time of the survey. The survey sample consisted of 13 current resident reviews (Residents #1 through #13) and two closed record reviews (Residents #14 and #15).

Plan of Correction

The submission of the Plan of Correction does not constitute Agreement on the part of the Woodlands Health & Rehab Center that deficiencies cited within the report represents deficient practices on the part of The Center and its staff.

F 001 Non Compliance

F 001

This plan represents our allegation of Compliance and our on-going pledge to Provide quality care that is rendered in Accordance with all regulatory Requirements. **08/25/15**

The facility was out of compliance with the following state licensure requirements:

This RULE: is not met as evidenced by:
The facility was not in compliance with 12 VAC 5-371, the Virginia Regulations for the Licensure of Nursing Facilities.

12 VAC 5-371-150 Resident Rights
12 VAC 5-371-150 (A) Cross Reference to F-225

12 VAC 5-371-110 Management and administration
12 VAC 5-371-110 (B.3) Cross Reference to F-226

12 VAC 5-371-180 Infection Control
12 VAC 5-371-180 (A) Cross Reference to F-441

12 VAC 5-371-220 Nursing Services
12 VAC 5-371-220 (A) Cross Reference to F-309
12 VAC 5-371-220 (A) Cross Reference to F-323

12 VAC 5-371-250 Resident Assessment and

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Care Planning
12 VAC 5-371-250 (D) Cross Reference to F-278
12 VAC 5-371-250 (F) Cross Reference to F-279

12 VAC 5-371-220 Nursing Services
12 VAC 5-371-220 (B) Cross Reference to F-332

12 VAC 5-371-300 Pharmaceutical Services
12 VAC 5-371-300 (B) Cross Reference to F-425
12 VAC 5-371-300 (B) Cross Reference to F-431

12 VAC 5-371-360 Clinical Records
12 VAC 5-371-360 (E.11) Cross Reference to F-283

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F 000	INITIAL COMMENTS	F 000		

An unannounced Medicare/Medicaid standard survey was conducted 07/14/2015 through 07/16/2015. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey.

The census in this 60 certified bed facility was 57 at the time of the survey. The survey sample consisted of 13 current resident reviews (Residents #1 through #13) and two closed record reviews (Residents #14 and #15).

This plan represents our allegation of Compliance and our on-going pledge to Provide quality care that is rendered in Accordance with all regulatory Requirements. 08/25/15

F 225 SS=D 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS

The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

F 225 **F Tag: 225 Cross reference 12 VAC 5-371-150 (A)**

Corrective Action:
The facility immediately investigated the information surrounding the bruised fractured hand and documented findings on the falls investigation sheet and timeline. The center failed to report to the state agency a bruised/fractured hand of unknown origin of resident #8.

Identifying Other Potential Residents:
Any resident has the potential to be affected if staff fails to thoroughly investigate and report to the state agency an injury of unknown origin.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Angela Baldwin | TITLE: Administrator | (X6) DATE: 7-29-15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	Continued From page 1 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to thoroughly investigate and report to the state agency an injury of unknown origin for one of 15 residents in the survey sample. The facility failed to thoroughly investigate and report to the state agency a bruised/fractured hand of unknown origin for Resident #8. The findings include: Resident #8 was admitted to the facility on 11/12/10 with diagnoses that included Alzheimer's dementia with behaviors, osteoporosis, coronary atherosclerosis, hyperlipidemia, vitamin D deficiency, depression, hypertension, optic atrophy, urinary tract infection and dysphagia. The minimum data set (MDS) dated 5/16/15 assessed Resident #8 with short and long-term memory problems and severely impaired cognitive skill for decision-making.	F 225	**Systemic Change:** Licensed professionals will be educated on the importance of thorough investigations, to include interviews with the resident, all staff (directly and indirectly) involved, any family, visitors or volunteers that may have been involved and to obtain written statements, as deemed necessary; to ensure mistreatment has not occurred, and proper reporting to state agency. Newly hired licensed professional will be educated on incident/accident procedures to ensure investigative procedures are adhered to with regulatory entities. **Monitoring:** The administrator, or designee, will review any reports of unknown injury daily Monday-Friday following the morning meeting x 4 weeks, then monthly x 2 months to ensure thorough investigation and reporting to state agency as required. Results will be reported to the QA Committee. **Date Completed:** **The facility will be in and will maintain Compliance with the requirement as of 8/25/15.**	08/25/15

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Resident #8's clinical record was reviewed on 7/14/15. Nursing notes documented the following regarding a large bruise and fracture of unknown origin found on the resident's left hand.

6/5/15 - "When CNA (certified nurses' aide) was getting resident up for the day it was brought to the attention of this nurse a large purplish area to the left hand. The purplish area covers the top left half of the left hand measuring 3 in (inches) long and 1.5 in (inches) wide it continues to the palm of the hand as a small blueish area...RP (responsible party) notified and did not wish to take any action as resident bumps into things often in her walker chair..." (sic)
6/26/15 - "Daughter in this evening. Spoke with nurse concerning her sisters hand. Requested Xray. Nurse spoke with NP (nurse practitioner) and new orders received to obtain xray of left hand..." (sic)
6/27/15 - "Xray done 6/27/15. Results received showing acute fifth metacarpal fracture...New orders for Iburprofen (Ibuprofen) and Ortho consult." (sic)

An x-ray report dated 6/27/15 documented the resident was diagnosed with an "acute/subacute fifth metacarpal fracture" of the left hand.

On 7/15/15 at 10:45 a.m. the director of nursing (DON) presented a copy of the facility's investigative report regarding the resident's bruised hand. The facility's investigation dated 6/5/15 stated, "CNA reported that as she was getting resident up for the day she noticed a large purplish bruise to L (left) hand both inner & outer aspects of hand...Large purplish bruise L hand - unknown origin." The investigation documented

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no written statements from staff members caring for the resident around the time of the injury. The report listed the CNA that reported the bruised hand and the nurse on duty when the bruise was discovered but did not identify other caregivers from previous shifts. The investigation made no mention of resident activities or events occurring during the days prior to the discovered bruise. On the back of the investigative report was a handwritten note stating, "CNA - 3-11 (CNA #2) - states nothing abnormal noted during pm care...11-7 (CNA #3) reported resident slept through the night." There was no documentation of the date/time this information was obtained, who wrote the notations or how the statements were obtained. The investigation documented, "determined not reportable at this time (due) to nature of injury in correlation to how resident walks in M/W (merry walker)...no evidence discovered of abusive nature." The report failed to describe any events or activities by the resident that could explain the bruised/fractured hand. The investigation made no mention the resident was diagnosed with a fractured left hand on 6/27/15. The facility had no separate investigation regarding the diagnosed fractured hand of unknown origin and there was no mention of any interview with the resident's responsible party about the fractured hand.

On 7/15/15 at 10:45 a.m. the DON was interviewed about the investigation regarding Resident #8's bruise/fracture of unknown origin. The DON stated she talked with the CNA and nurse working when the bruise was discovered on 6/5/15 and they reported "nothing unusual." The DON stated the family later requested an x-ray because of continued swelling and that was when the fracture was discovered. The DON

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stated they did not obtain written statements from any staff members. The DON stated she called the CNAs caring for Resident #8 on the previous day and they reported nothing unusual. The DON stated she wrote the notes on the back of the investigation report regarding her phone conversations with CNAs. When asked if they conducted any further investigation after discovering the resident's hand was fractured, the DON stated, "No." The DON stated they thought the resident probably bumped into something while walking in her merry walker.

On 7/15/15 at 3:00 p.m. the administrator presented a timeline stating she reviewed the incident on 7/6/15 and did not consider it reportable to the state agency. The timeline presented listed the incident as not reportable because the resident had a history of falls, bumps into things, wandered and had a diagnosis of osteoporosis.

The facility's investigation documented no evidence of falls, bumps or incidents involving Resident #8 around the time of the bruising and diagnosed fracture.

The facility's policy titled Abuse Prevention (revised 5/25/12) documented, "The facility is committed to maintaining a safe and abuse-free environment for all residents and committed to a comprehensive investigation of any allegation of activities or situations that may constitute abuse. Corrective and preventive action to minimize recurrence will be developed and implemented on an individual resident and on a facility basis. Outside agencies, including regulatory agencies, ombudsman, protective services, police, etc. will be notified and involved as appropriate to the

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F 225	Continued From page 5 situation...The facility will investigate and report incidents or occurrences in accordance with federal and state guidelines..." The facility's policy titled Abuse/Neglect Injuries of Unknown Origin Guidelines (revised 7/21/08) stated, "The Administrator, Director of Nursing, or their designee, must begin a documented investigation of the (cause of the) injury using the Commonwealth Care Investigative Report form...The investigation will include interviews with the resident, all staff involved (directly or indirectly), (roommate/residents if alert), any family, visitors, or volunteers which may have had contact with the resident and may help with the investigation. Obtain written statements (for all interviews) as deemed necessary..." These findings were reviewed with the administrator and director of nursing during a review meeting on 7/15/15 at 4:50 p.m.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to follow their abuse prevention policies to thoroughly investigate and report an injury of unknown origin for one of 15 residents in the survey sample. The facility had no evidence of a	F 226	**F Tag: 226 Cross reference 12 VAC 5-371-110(B.3)** **Corrective Action:** The investigation of the incidents surrounding Resident #8's hand was documented and included the orthopedic consult stating the finger fracture was 6-8 weeks old. **Identifying Other Potential Residents:** Any resident has the potential of being affected if staff fail to follow abuse prevention policies to thoroughly investigate and report an injury of unknown origin.	

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F 226	Continued From page 6 thorough investigation regarding a bruised and fractured left hand for Resident #8 and failed to report the incident to the state agency. The findings include: Resident #8 was admitted to the facility on 11/12/10 with diagnoses that included Alzheimer's dementia with behaviors, osteoporosis, coronary atherosclerosis, hyperlipidemia, vitamin D deficiency, depression, hypertension, optic atrophy, urinary tract infection and dysphagia. The minimum data set (MDS) dated 5/16/15 assessed Resident #8 with short and long-term memory problems and severely impaired cognitive skill for decision-making. Resident #8's clinical record was reviewed on 7/14/15. Nursing notes documented the following regarding a large bruise and fracture of unknown origin found on the resident's left hand. 6/5/15 - "When CNA (certified nurses' aide) was getting resident up for the day it was brought to the attention of this nurse a large purplish area to the left hand. The purplish area covers the top left half of the left hand measuring 3 in (inches) long and 1.5 in (inches) wide it continues to the palm of the hand as a small blueish area...RP (responsible party) notified and did not wish to take any action as resident bumps into things often in her walker chair..." (sic) 6/26/15 - "Daughter in this evening. Spoke with nurse concerning her sisters hand. Requested Xray. Nurse spoke with NP (nurse practitioner) and new orders received to obtain xray of left hand..." (sic) 6/27/15 - "Xray done 6/27/15. Results received showing acute fifth metacarpal fracture...New	F 226	**Systemic Change:** Licensed professionals will be educated on importance of thorough investigations, to include interviews with the resident, all staff (directly and indirectly) involved, any family, visitors of volunteers that may have been involved and to obtain written statement, as deemed necessary; to ensure mistreatment has not occurred and the proper process of reporting to regulatory entities as required. Newly hired licensed professionals will be educated on incident/accident procedures to ensure investigative procedures are adhered to with regulatory entities and that all reportable incidents are reported within the appropriate time-frame. **Monitoring:** The administrator, or designee, will review any reports of unknown injury daily Monday-Friday following the morning meeting X 4 weeks, then monthly X 2 months to ensure thorough investigation and reporting to state agency as required. Results will be reported to the QA committee. **Date Completed:** **The facility will be in and maintain Compliance with the requirement as of 8/25/15**	08/25/15

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orders for Iburprofen (Ibuprofen) and Ortho consult." (sic)

An x-ray report dated 6/27/15 documented the resident was diagnosed with an "acute/subacute fifth metacarpal fracture" of the left hand.

On 7/15/15 at 10:45 a.m. the director of nursing (DON) presented a copy of the facility's investigative report regarding the resident's bruised hand. The facility's investigation dated 6/5/15 stated, "CNA reported that as she was getting resident up for the day she noticed a large purplish bruise to L (left) hand both inner & outer aspects of hand...Large purplish bruise L hand - unknown origin." The investigation documented no written statements from staff members caring for the resident around the time of the injury. The report listed the CNA that reported the bruised hand and the nurse on duty when the bruise was discovered but did not identify other caregivers from previous shifts. The investigation made no mention of resident activities or events occurring during the days prior to the discovered bruise. On the back of the investigative report was a handwritten note stating, "CNA - 3-11 (CNA #2) - states nothing abnormal noted during pm care...11-7 (CNA #3) reported resident slept through the night." There was no documentation of the date/time this information was obtained, who wrote the notations or how the statements were obtained. The investigation documented, "determined not reportable at this time (due) to nature of injury in correlation to how resident walks in M/W (merry walker)...no evidence discovered of abusive nature." The report failed to describe any events or activities by the resident that could explain the bruised/fractured hand. The investigation made no mention the resident

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was diagnosed with a fractured left hand on 6/27/15. The facility had no separate investigation regarding the diagnosed fractured hand of unknown origin and there was no mention of any interview with the resident's responsible party about the fractured hand.

On 7/15/15 at 10:45 a.m. the DON was interviewed about the investigation regarding Resident #8's bruise/fracture of unknown origin. The DON stated she talked with the CNA and nurse working when the bruise was discovered on 6/5/15 and they reported "nothing unusual." The DON stated the family later requested an x-ray because of continued swelling and that was when the fracture was discovered. The DON stated they did not obtain written statements from any staff members. The DON stated she called the CNAs caring for Resident #8 on the previous day and they reported nothing unusual. The DON stated she wrote the notes on the back of the investigation report regarding her phone conversations with CNAs. When asked if they conducted any further investigation after discovering the resident's hand was fractured, the DON stated, "No." The DON stated they thought the resident probably bumped into something while walking in her merry walker.

On 7/15/15 at 3:00 p.m. the administrator presented a timeline stating she reviewed the incident on 7/6/15 and did not consider it reportable to the state agency. The timeline presented listed the incident as not reportable because the resident had a history of falls, bumps into things, wandered and had a diagnosis of osteoporosis.

The facility's investigation documented no

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evidence of falls, bumps or incidents involving Resident #8 around the time of the bruising and diagnosed fracture.

The facility's policy titled Abuse Prevention (revised 5/25/12) documented, "The facility is committed to maintaining a safe and abuse-free environment for all residents and committed to a comprehensive investigation of any allegation of activities or situations that may constitute abuse. Corrective and preventive action to minimize recurrence will be developed and implemented on an individual resident and on a facility basis. Outside agencies, including regulatory agencies, ombudsman, protective services, police, etc. will be notified and involved as appropriate to the situation...The facility will investigate and report incidents or occurrences in accordance with federal and state guidelines..." The facility's policy titled Abuse/Neglect Injuries of Unknown Origin Guidelines (revised 7/21/08) stated, "The Administrator, Director of Nursing, or their designee, must begin a documented investigation of the (cause of the) injury using the Commonwealth Care Investigative Report form...The investigation will include interviews with the resident, all staff involved (directly or indirectly), (roommate/residents if alert), any family, visitors, or volunteers which may have had contact with the resident and may help with the investigation. Obtain written statements (for all interviews) as deemed necessary..."

These findings were reviewed with the administrator and director of nursing during a review meeting on 7/15/15 at 4:50 p.m.

F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	F 278	F Tag: 278 Cross reference 12 VAC 5-371-250 (D)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 10 The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure an accurate minimum data set (MDS) assessment for one of 15 residents in the survey sample. Resident #13's MDS dated 3/12/15 included no assessment of cognitive patterns, signs/symptoms of delirium or mood.	F 278	**Corrective Action:** An assessment of cognitive patterns, signs/symptoms of delirium or mood was completed on Resident #13 on 03/18/15. **Identifying other potential residents:** Any resident has the potential to be affected if the MDS is not completely documented. A 100% audit of all assessments completed in past 2 weeks on section C, D interview sections will be completed to assure coding to RAI manual instructions. **Systemic Change:** Social Worker and MDS Coordinator will be educated by Regional RAI Consultant on Chapter 3, section C & D of the MDS and for other resident interviews per RAI guidance. **Monitoring:** MDS Coordinator or designee will audit 100% of section C, D interview sections weekly x 12 weeks to assure completion per RAI manual. Findings will be reported to QA for Follow-up. **Date Completed:** **The facility will be in and maintain Compliance with the requirement as of 8/25/15**	08/25/15

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	495360	A. BUILDING _____ B. WING _____	07/16/2015

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The findings include:

Resident #13 was admitted to the facility on 8/14/13 with a re-admission on 3/5/15. Diagnoses for Resident #13 included dementia, psychosis, hypertension, atrial fibrillation, diabetes, anxiety, peripheral neuropathy, depression, osteoporosis, gastroesophageal reflux disease and nuclear sclerosis. The MDS dated 6/12/15 assessed Resident #13 with moderately impaired cognitive skills.

Resident #13's clinical record was reviewed on 7/15/15. The record documented a MDS assessment dated 3/12/15 due to a significant change in the resident's status. This MDS documented no assessment of the resident's cognitive patterns, signs/symptoms of delirium and mood. Sections C and D for recording these assessment areas were completed with dashes and had no assessment codes.

The administrator, director of nursing and MDS coordinator were made aware of these findings on 7/15/15 at 4:50 p.m. The registered nurse MDS coordinator (RN #4) was asked at this time about the incomplete MDS assessment for Resident #13.

On 7/16/15 at 8:30 a.m. RN #4 stated sections C and D of Resident #13's MDS dated 3/12/15 were not completed. RN #4 stated the social worker was responsible for completing the assessments regarding cognitive patterns, delirium and mood. Regarding Resident #13's assessment dated 3/12/15, RN #4 stated dashes were entered on the MDS form because the assessments were not completed timely. RN #4 stated the

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F 278	Continued From page 12 assessments for cognitive patterns, delirium and mood were supposed to be done on the day before or day of the MDS assessment reference date.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility staff failed, for one of 15 residents in the survey sample (Resident # 3), to develop a plan of care that addressed the resident's need for assistance with transfers. The transfer needs of Resident # 3, who was assessed as needing extensive assistance with	F 279	**F tag: 279 Cross reference to 12 VAC 5-371-250(F)** **Corrective Action:** The Care Plan for Resident #3 was reviewed and accurately describes the appropriate level of physical assistance needed with transfers. (Mobility care plan-1 staff assistant with mobility provided weight-bearing support, praising efforts) **Identifying other potential residents:** Any resident may be affected if the staff fail to develop a plan of care that addresses the resident's need for assistance with transfers. Current care plans will be audited to ensure transfer status is addressed appropriately/accurately. **Systemic Changes:** Licensed staff will be educated on care plan revisions where appropriate staff assistance may vary over the course of the day and the resident may need physical assist of 1-2 person(s). **Monitoring:** Audit 5 care plans weekly x 4 weeks, then monthly x 2 to ensure accurate transfer status is addressed.	

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F 279	Continued From page 13	F 279	**Date Completed:** **The facility will be in and maintain Compliance with the requirement as of 8/25/15**	08/25/15

two persons physical assist, were not covered in the plan of care.

The findings were:

Resident # 3 in the survey sample, a 71 year-old male, was admitted to the facility on 1/17/13, and most recently readmitted on 12/8/14 with diagnoses that included diabetes mellitus, cardiomyopathy, convulsions, congestive heart failure, anemia, renal failure, depressive disorder, vascular dementia, late effects of cerebrovascular disease, gastroesophageal reflux disease, hypertension, hyperlipidemia, asthma, nuclear sclerosis, and anxiety state. According to the most recent Minimum Data Set, a Significant Change with an Assessment Reference Date of 6/5/15, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 14 out of 15.

Under Section G (Functional Status) the resident was assessed as needing extensive assistance with two persons physical assist for transfer and bed mobility; as needing extensive assistance with one person physical assist for walking in the unit corridor, locomotion on and off the nursing unit, dressing, personal hygiene and bathing; and as needing supervision with set-up help only for eating.

Review of Resident # 3's care plan, updated after the Significant Change assessment of 6/5/15, noted the following problem in the area of Activities of Daily Living (ADLs), "Mr. (name of resident) requires assistance with ADLs r/t (related to) after effects of CVA (Cerebrovascular Accident)." The goals for the problem in ADLs were, "Mr. (name of resident) will be clean and

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dressed in clothing of his choice through next review; Mr. (name of resident) will not experience an avoidable decline in ADLs through the next review."

The approaches to the stated problem were:

"Direct care staff to notify nurse of any concerns w/ (with) resident decline in self ADL performance (decline) (sic).

Mr. (name of resident) prefers his personal items left out for ease of access.

Occupational therapy to screen/eval (evaluate) as indicated prn (as needed) per physician orders.

Requires assistance with upper extremities dressing.

Resident require (sic) assistance with lower extremity dressing.

Resident requires assistance with bathing.

Resident requires assistance with daily hygiene routine."

None of the approaches to the Activities of Daily Living problem dealt with the resident's need for extensive assistance with two persons assist for transfers.

The lack of care planning for transfers was discussed during a meeting with the administrative staff at 4:45 p.m. on 7/15/15, which included the Administrator, the Director of Nursing, the MDS Coordinator, and the survey team. During the meeting, the administrative

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staff raised the question as to whether or not the assessment of Resident # 3 needing extensive assistance with two persons physical assist for transfers was accurate or not.

At 8:30 a.m. on 7/16/15, the Administrator provided the surveyor with documentation covering the seven day look-back period (5/30/15 - 6/5/15) for the assessment area of Transfers under Section G (Functional Status). According to the documentation, the resident needed the physical assistance of two persons for transfer three times during the look-back period (on 6/1/15, 6/3/15, and 6/4/15), and the assistance of one person for transfers 13 times during the look-back period.

At approximately 9:00 a.m. on 7/16/15, RN # 4 (Registered Nurse), the MDS Coordinator, explained to the surveyor that according the the MDS Rule of Three, Resident # 3 had to be assessed as needing extensive assistance with two persons physical assist even though he only required two persons assist three times during the look-back period.

The CMS RAI Manual notes the following for the Rule of Three:

"Instructions for the Rule of Three:
When an activity occurs three times at multiple levels, code the most dependent.
Example, three times extensive assistance (3) and three times limited assistance (2) - code extensive assistance (3)." (Ref. CMS's RAI Version 3.0 Manual, Chapter 3, page G-4, September 2010.)

F 283 483.20(l)(1)&(2) ANTICIPATE DISCHARGE: F 283 F tag: 283 Cross reference 12 VAC 5-371-360 (E.11)

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F 283 SS=D	Continued From page 16 RECAP STAY/FINAL STATUS When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed, for one of 15 residents in the survey sample (Resident # 14), to ensure that a complete and accurate discharge summary was completed as a part of the resident's discharge from the facility. The discharge summary for Resident # 14 failed to include a recapitulation of the resident's stay, comments on the resident's rehabilitation potential, and a summary of the care provided to the resident during his stay at the facility. The findings were: Resident # 14 in the survye sample, a 71 year-old male, was admitted to the facility on 3/10/15 with diagnoses that included generalized muscle weakness, difficulty walking, late effects of cerebrovascular disease, dementia, aphasia, syncope and collapse, diabetes mellitus, vitamin D deficiency, gastroesophageal reflux disease, hypercholesterolemia, and cognitive communication deficit. According to an Initial 5-Day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 3/17/15,	F 283	**Corrective Action:** A discharge summary was completed on 07/30/15 for Resident #14. **Identifying other potential residents:** Any resident has the potential to be affected if staff fail to ensure a complete and accurate discharge summary. 100% audit of discharge records within past 90 days for accuracy and completed discharge summaries. **Systemic Changes:** Discharge summaries will be initiated within 24 hours of discharge from facility. Staff will be educated regarding completion of the discharge summary. After completion, the discharge summary will then be printed and placed in MD book for review and signature. Medical records will review record for discharged patient within 72 hours of discharge to ensure summary was completed and then submit to physician for appropriate signature. **Monitoring:** The administrator or designee will audit discharge summaries for completion weekly x 12 weeks. **Date Completed:** **The facility will be in and maintain Compliance with the requirement as of 8/25/15**	08/25/15

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the resident was assessed under Section C (Cognitive Patterns) as being severely cognitively impaired, with a Summary Score of 3 out of 15.

According to a Discharge - Return Not Anticipated MDS with an ARD of 5/22/15, the resident was assessed under Section C (Cognitive Patterns) as being moderately cognitively impaired, with a Summary Score of 8 out of 15.

Resident # 14 was discharged to his home on 5/22/15.

Review of Resident # 14's closed clinical record revealed the following Physician's Telephone Orders:

5/14/15 - "Arrange for HH (Home Health), PT/OT/ST/SN (Physical Therapy/Occupational Therapy/Speech Therapy/Skilled Nursing) in prep (preparation)/anticipation of discharge to home."

5/20/15 - "D/C (Discontinue) SLP (Speech Language Pathology) since Pt (patient) has met STG's (short term goals) and is going home."

5/21/15 - "Late entry: Effective 5/20/15 D/C from PT services secondary to reaching STG/LTG (long term goals).'

5/22/15 - "Resident to D/C home on 5/22/15 with home health services , SN, PT, OT, ST."

Resident # 14's clinical record also included a Discharge Summary with an effective date of 5/22/15. Review of the Discharge Summary noted the following:

At Item A. "Please provide a recapitulation of the

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F 283	Continued From page 18 resident's stay," there was no recapitulation provided. At Item C."REHAB: What was the Rehabilitation potential for this resident?" there was no entry regarding Resident # 14's rehabilitation potential. At Item E. "Summary of Care: Give a brief summary of care while at the facility," there was no entry summarizing the resident's care while at the facility. At 4:30 p.m. on 7/15/15, the surveyor asked the Medical Records clerk to identify the signature at the bottom of the Discharge Summary. The Medical Records clerk identified the signature as that of the Nurse Practitioner. The signature was dated 5/26/15.	F 283		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility staff failed, for one of 15 residents in the survey sample (Resident # 4), to offer or to attempt non-pharmacological interventions to address pain before the administration of pain medication. Resident # 4	F 309	**F tag; 309 Cross reference 12 VAC 5-371-220 (A)** **Corrective Action:** Pain medication was administered to resident #4 was duly noted and care plan was reviewed for non-pharmacological interventions. **Identifying other potential residents:** Any resident who utilizes PRN analgesics has the potential to be affected if staff fail to offer, or to attempt non-pharmacological interventions to address pain before the administration of pain medication.	

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F 309	Continued From page 19	F 309	**Systemic Changes:**	

was administered pain medication 37 times without non-pharmacological interventions being offered or attempted.

The findings were:

Resident # 4 in the survey sample, a 91 year-old female, was admitted to the facility on 9/27/12, and most recently readmitted on 5/27/15 with diagnoses that included status post pathologic hip fracture, generalized muscle weakness, anemia, osteoporosis, osteoarthrosis, anxiety state, hypertension, senile dementia, abnormal posture, depressive disorder, urinary tract infection, and hyperlipidemia. According to the most recent MDS, a Significant Change with an ARD of 6/3/15, the resident was assessed under Section C (Cognitive Patterns) as being severely cognitively impaired, with a Summary Score of 5 out of 15.

Resident # 4 had the following physician's order, dated 6/2/15, for PRN (as needed) pain medication related to the aftercare of her hip fracture:

"Hydrocodone-Acetaminophen tablet 10-325 mg (milligrams). Give 1 tablet by mouth every 6 hours as needed for pain related to aftercare for healing pathologic fracture of hip."

Review of the Progress (Nurses) Notes in Resident # 4's clinical record revealed the following entry:

6/2/15 - 2:23 p.m. "Note Text: Hydrocodone-Acetaminophen tablet 10-325 mg. Give 1 tablet by mouth every 6 hours as needed for pain related to aftercare for healing pathologic

Licensed staff will be educated to ensure appropriate non-pharmacological interventions are attempted / documented prior to PRN administration of analgesics.

Monitoring:
Random audits of resident records with orders for PRN analgesic medications will be performed weekly x4, then monthly x2 to assure offering of non-pharmacological interventions. Results will be reported to QAA committee for review and analysis.

Date Completed:
The facility will be in and maintain Compliance with the requirement as of 8/25/15 — **08/25/15**

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F 309	Continued From page 20 fracture of hip." Further review of the Progress (Nurses) Notes revealed the 6/2/15 entry was repeated 37 times between 6/2/15 and 7/14/15. Also included in the Progress (Nurses) Notes were another 37 entries, also between 6/2/15 and 7/14/15, attesting to the effectiveness of each administration of pain medication. At 11:55 a.m. on 7/15/15, the Director of Nursing (DON) was interviewed regarding non-pharmacological interventions to address the resident's pain. The DON said the interventions "...should be on the (resident's) care plan, and the interventions should be documented in the progress notes." Review of the Progress (Nurses) Notes in the clinical record of Resident # 4 for the period 6/2/15 through 7/14/15 failed to reveal any documentation of non-pharmacological interventions being offered or attempted before the administration of pain medication.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 323	**F tag: 323 Cross reference to 12 VAC 5-371-220(A)** **Corrective Action:** Resident #3's care plan was reviewed and reflects transfer assistance of 1 person. **Identifying other potential residents:** Any resident has the potential for being affected if staff fail to transfer the resident in a safe manner.	

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Based on clinical record review, resident interview, staff interview, and review of facility documents, the facility staff failed, for one of 15 residents in the survey sample (Resident # 3), to transfer the resident in a safe manner. Resident # 3, who required the assistance of two persons for transfer, slipped to the floor during a one person assisted transfer and sustained a minor skin tear.

The findings were:

Resident # 3 in the survey sample, a 71 year-old male, was admitted to the facility on 1/17/13, and most recently readmitted on 12/8/14 with diagnoses that included diabetes mellitus, cardiomyopathy, convulsions, congestive heart failure, anemia, renal failure, depressive disorder, vascular dementia, late effects of cerebrovascular disease, gastroesophageal reflux disease, hypertension, hyperlipidemia, asthma, nuclear sclerosis, and anxiety state. According to the most recent Minimum Data Set, a Significant Change with an Assessment Reference Date of 6/5/15, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 14 out of 15.

Under Section G (Functional Status) the resident was assessed as needing extensive assistance with two persons physical assist for transfer and bed mobility; as needing extensive assistance with one person physical assist for walking in the unit corridor, locomotion on and off the nursing unit, dressing, personal hygiene and bathing; and as needing supervision with set-up help only for eating.

Review of the Progress (Nurses) Notes in

Systemic Changes:
Nursing staff will be educated on assessing and providing safe transfers for residents, including residents with varying dependence.

100% audit on all current residents to ensure appropriate transfer status in place

Monitoring:

Audit transfer status of 5 residents per week X 12 weeks and randomly observe the transfers.
Report findings to QA Committee.

Date Completed:
The facility will be in and maintain Compliance with the requirement as of 8/25/15 — **08/25/15**

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F 323	Continued From page 22	F 323		

Resident # 3's clinical record revealed the following entry:

7/3/15 - 6:32 a.m. "CNA (Certified Nursing Assistant) informed nurse that while transferring resident, resident lost footing and CNA assisted resident to floor. While assisting resident to floor he attempt (sic) to grab hold of wheelchair with left hand and receive (sic) a skin tear to left outer hand. Stated that he lost his footing and CNA helped him to floor and did not hit his head. Assessed resident. ROM (Range of Motion) WNL (Within Normal Limits) for resident. Cleaned and dressed skin tear to left hand. Assisted resident to chair, 2 persons assisted. MD/NP and RP (Responsible Party) notified."

At 4:00 p.m. on 7/14/15, Resident # 3 was interviewed while he was in the facility's Dining Room. Except for a dining services staff member who was setting tables for the evening meal, the Dining Room was unoccupied. The resident, who was seated in his wheelchair, had a dressing on his left hand, and a dressing on his left foot. The dressing on the resident's left foot was for a heel blister, identified on 6/1/15, that slowly developed into a Stage II pressure ulcer. The dressing was on the resident's foot at the time of the fall on 7/3/15.

Asked if he could describe what happened to his hand, Resident # 3 said, "I was getting into my wheelchair and I slipped. I cut my hand on my wheelchair." Resident # 3 also indicated that the dressing on his left foot made it difficult for him to stand. Asked how many CNA's were helping him when he slipped, Resident # 3 responded, "One."

At 9:15 a.m. on 7/15/15, the Director of Nursing

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F 323	Continued From page 23 (DON) was interviewed regarding Resident # 3's fall on 7/3/15. Asked if the CNA assisting the resident was using a gait belt at the time, the DON said, "I don't know." Asked if she knew how Resident # 3 was assessed for transfers, the DON said, "Off the top of my head, I don't know." Asked how many CNA's were assisting the resident at the time of his fall, the DON said, "There was one CNA." Review of the facility's incident report of the fall noted only that a fall had occurred. There were no details as to the nature of the fall or the number of staff involved.	F 323		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on medication pass observations, staff interview and clinical record review, the facility staff failed to ensure a medication error rate of less than five percent. Medication pass observations on 7/15/15 had two medication errors out of 25 opportunities resulting in an eight percent error rate. 1. The extended release medication Metoprolol was crushed prior to administration to Resident #6. 2. RN #1(registered nurse) failed to obtain a B/P (blood pressure) prior to the administration of	F 332	**F tag: 332 Cross reference to 12 VAC 5-371-220(B)** **Corrective Action:** The Medical Director was notified of the Medication that was crushed for Resident #6 and no further instructions were given. The Blood Pressure was immediately obtained for Resident #12 and was appropriate for administration of Lisinopril per physician order. Nurses who committed medication errors on resident #12 and resident #6 were counseled regarding errors and medication administration procedures.	

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F 332	Continued From page 24 Lisinopril per the physician order for Resident #12. The findings include: 1. The extended release medication Metoprolol was crushed prior to administration to Resident #6. A medication pass observation was conducted on 7/15/15 at 7:40 a.m. with registered nurse (RN) #4 preparing and administering medications to Resident #6. Among the medications prepared for Resident #6 was a tablet of Metoprolol ER (extended release) 50 mg (milligrams). RN#4 crushed this extended release medication along with other medicines and then administered them to Resident #13. Resident #6's clinical record documented a current physician's order for Metoprolol ER 50 mg to be administered each morning. On 7/15/15 at 8:00 a.m. RN #4 was interviewed about crushing the extended release Metoprolol. RN #4 stated, "I don't think we are supposed to crush that (extended release). She (Resident #6) can't swallow pills." On 7/17/15 at 10:20 a.m. the director of nursing (DON) presented a reference list used by the facility titled "Medications Not To Be Crushed." Included on this do not crush list was Metoprolol extended release. The Drug Information Handbook for Nursing 13th Edition on page 801 describes Metoprolol as a beta blocker used for the treatment of angina	F 332	**Identifying other potential residents:** Any resident has the potential of being affected by inappropriate medication administration if they are not administered per physician order. **Systemic Changes:** **Licensed staff will be educated on medication administration procedures as related to following specific medication parameters and referring to the "do not crush" medication list.** Copies of the facility list "Medications Not To Be Crushed" will be placed on each medication cart. The Medication bags from Pharmacy will include blackbox warnings/administration precautions. **Monitoring:** Random audits of appropriate medication administration / set parameters to be conducted weekly x4 weeks on varying shifts, then monthly x2. Results will be reported to QAA committee for review and analysis. DON or designee will conduct med pass observation with a nurse 2 x weekly x 4 weeks on varying shifts, and 2 x monthly on varying shifts to ensure medications administered as ordered/set parameters followed as ordered. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance committee for review and further analysis of findings	

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F 332	Continued From page 25	F 332	**Date Completed:** **The facility will be in and maintain Compliance with the requirement as of 8/25/15**	**08/25/15**

pectoris and hypertension. Page 803 of this references states concerning oral administration of Metoprolol, "Extended release tablets may be divided in half; do not crush or chew." (1)

These findings were reviewed with the administrator and director of nursing on 7/15/15 at 4:50 p.m.

(1) Turkoski, Beatrice B., Brenda R. Lance and Elizabeth A. Tomsik. Drug Information Handbook for Nursing. Hudson, Ohio: Lexi-Comp, 2011.

2. RN #1(registered nurse) failed to obtain a B/P (blood pressure) prior to the administration of Lisinopril per the physician order for Resident #12.

Resident #12 was admitted to the facility in September 2014 with diagnoses including, but not limited to: Dementia with Behaviors, Hypertension, Hypothyroidism, Anemia, Depression, Convulsions and Intracerebral Hemorrhage.

The most recent MDS(minimum data set) was a significant change assessment with an ARD (assessment reference date) of 04/20/2015. Resident #12 was assessed as cognitively intact with a total cognitive score of 15 out of 15.

On 07/15/15 at approximately 8:00 a.m., during a medication pass observation with RN #1, Resident #12 received Lisinopril 40 mg (milligrams) by mouth. After RN #1 administered the Lisinopril to Resident #12 she went to the EMR (electronic medical record) of this Resident to sign off the Lisinopril had been given. When she clicked on Lisinopril in the EMR a box was

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F 332	Continued From page 26 generated on the MAR (medication administration record). The box was to enter a current B/P reading. RN #1 stated, "Oh, I didn't see it before. I should have checked her B/P before giving." She immediately obtained a B/P on this Resident and recorded it on the MAR. At approximately 8:30 a.m., while reconciling the medication pass observation with the physician orders an order was noted that stated, "Lisinopril 40 mg po (orally)...Hold if SBP (systolic blood pressure) < (less than) 90." RN #1 was informed this would count as a medication error. The Administrator and DON (director of nursing) were informed of this incident during a meeting with the survey team on 07/15/2015 at approximately 4:45 p.m. No further information was obtained prior to the exit conference on 07/16/2015.	F 332		
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 425	**F tag: 425 Cross reference to 12 VAC 5-371-300(B)** **Corrective Action:** An alternate pain medication was administered to Resident #5 per physician order until appropriate pain medication was received for each incident. Nurses who failed to ensure pain medication available for resident were educated regarding proper policy for obtaining medications. No negative outcome identified for resident #5.	

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F 425	Continued From page 27 The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, facility staff failed to ensure medications were available for administration for one of 15 residents in the survey sample, Resident #5. Fentanyl patches were not available in the facility on four occasions for Resident #5. Findings included: Resident #5 was originally admitted to the facility on 08/01/2012 and readmitted on 04/21/2015 with diagnoses including, but not limited to: Congestive Heart Failure, Dementia, Diabetes Mellitus, Osteoarthrosis, Anxiety, Depression, Hypertension and Chronic Pain. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 06/03/2015. Resident #5 was assessed as severely impaired in her cognitive skills with a total cognitive score of five out of 15. During the clinical record review on 07/14/2015 at approximately 3:00 p.m., an order for Duragesic (Fentanyl) patches was noted. The order on the current POS (physician order sheet) for July 2015 stated, "...Duragesic-100 Patch 72 Hour 100 MCG/HR (micrograms per hour) (Fentanyl) Apply	F 425	**Identifying other potential residents:** Any residents has the potential for being affected by not having medications available as per physician order. **Systemic Changes:** Licensed nursing staff will be educated on proper protocol for re-ordering and obtaining pain medication from the pharmacy when it is not available in the center. Nurses will contact Nursing Administration whenever meds are not available for further instruction on proper procedures. **Monitoring:** Audits of re-ordered medications will be conducted 3 x weekly on varying shifts x 2 weeks, weekly x 2, then monthly x 2. Results will be reported to the QAA committee for review and analysis. DON or designee will review center 24 hour report daily (M-F) x4 weeks, weekly x4 weeks, and monthly x1 month to ensure pain medications are administered per MD order. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance committee for review and further analysis of findings **Date Completed:** **The facility will be in and maintain Compliance with the requirement as of 8/25/15**	08/25/15

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100 mg transdermally at bedtime every 3 day(s)..." Order date: 05/02/2015. Start date: 05/02/2015.

Review of the May and June 2015 MAR's (medication administration records) for Resident #5 revealed the following: Sunday, May 17, Wednesday May 20, Sunday, June 7 and Monday, June 22 all had a number "9" with a nurse's initials documented in the administration box on the MAR. Under the section of "Chart Codes/Follow Up Codes" on the MAR, a "9" is defined as "Other/See Nurse Notes."

Review of "Progress Notes" corresponding with the above dates were noted as follows: 05/17/15 at 5:06 a.m., "Note Text: Duragesic-100 Patch 72 Hour 100 MCG/HR Apply 100 mg transdermally at bedtime every 3 day(s)...unavailable, on order, pharmacy notified." 05/20/15 at 6:33 a.m., "Note Text: unavailable pharmacy notified." 06/07/15 at 5:24 a.m., "...NOT AVALIBLE." (sic) 06/22/15 at 5:09 a.m., "...not avaliable." (sic)

On 07/15/2015 at approximately 11:45 a.m., during a meeting with the survey team, the Administrator and DON (director of nursing) were interviewed regarding the unavailability of this medication. The DON stated, "I will have to look into it and get back with you."

During a second meeting with the survey team on 07/15/2015 at approximately 5:05 p.m., the DON was again interviewed regarding the unavailability of this medication. The DON stated, "I emailed (name) at the pharmacy. They are investigating this on their end. I haven't heard back yet."

At approximately 8:20 a.m. on 07/16/2015, the

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F 425	Continued From page 29 Administrator was asked if the facility had heard anything from the pharmacy regarding the above. She stated, "I'm not sure. (Name) the DON is working on that. I will let her know you are asking about it." At approximately 8:30 a.m., the DON came to the conference room with some copies of information from Resident #5's medical record. The DON stated, "On one occasion the medication was late getting to the facility. The nurse applied the patch as soon as she got it. The other occasions, I believe the medication was ordered too early in the electronic system and so the pharmacy didn't fill it. Therefore, when it was time for the patch to be changed, none had come from the pharmacy. It is a glitch in the system we will have to work out." No further information was received by the survey team prior to the exit conference on 07/16/2015.	F 425		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 431	**F tag: 431 Cross reference to 12 VAC 5-371-300(B)** **Corrective Action:** The 3 insulin pens were immediately discarded on 7/15/15. **Identifying other potential residents:** Any resident has the potential to be affected if staff fail to remove expired medication from the supply. All medications currently within the pharmacy refrigerator were reviewed by charge nurse and nursing management to ensure no expired medications exist including patient specific medications as well as stat medications.	

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F 431	Continued From page 30 applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on medication room observation and staff interview, facility staff failed to ensure expired drugs and biologicals were not available for administration in the medication refrigerator. Facility staff failed to remove three, expired NPH (Humulin-N) insulin pens from the medication refrigerator. Findings included: On 07/15/2015 at approximately 3:40 p.m., the medication room on the nursing unit was inspected by this surveyor and RN #1 (registered nurse). Inspection of the refrigerator in the medication room, designated for Resident medications revealed the following: Three (3)	F 431	**Systemic Changes:** When the stat box is replaced with new medications, a list containing the enclosed medications with expiration dates will be present on the outside of the box for easy identification of contents and expiration dates. Licensed Staff will be educated on the revised stat box procedure. **Monitoring:** DON or designee will audit refrigerator weekly x 4 weeks then monthly x 2 months to ensure medications aren't expired. **Date Completed:** **The facility will be in and maintain Compliance with the requirement as of 8/25/15**	08/25/15

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Humulin-N insulin pens, 100u/ml (units per milliliter) - 3ml each, with expiration dates of 10/2014.

RN #1 was shown the expired insulin pens. She stated, "The pharmacy was just here yesterday and checked this refrigerator. I don't know how they missed that." RN #1 removed the unused insulin pens from the refrigerator and medication room.

The Administrator and DON (director of nursing) were informed of the above findings during a meeting with the survey team on 07/15/2015 at approximately 4:45 p.m.

No further information was received by the survey team prior to the exit conference on 07/16/2015.

F 431

F 441 SS=D 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection

F 441

F tag: 441 Cross reference to 12 VAC 5-371-180(A)

Corrective Action:
Staff were immediately educated on appropriate procedure for ice distribution. The nurse was educated on proper handwashing procedure and the removal of her brace.

Identifying other potential residents:
Any resident has a potential for being affected by spread of infection related to improper hand hygiene and unsanitary ice distribution

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F 441	Continued From page 32	F 441	**Systemic Changes:** Nursing staff will be educated on Infection Control measures to prevent the spread of germs as required per regulatory entities, including, but not limited to, hand hygiene and ice distribution procedures. New hires will be oriented on general infection control and prevention techniques, including handwashing technique and ice distribution procedure, to aid in preventing the spread of germs. **Monitoring:** DON or designee will perform random audits of facility to ensure appropriate infection control procedures, handwashing, and ice distribution to prevent spread of infection 5 x weekly x 2 weeks on varying shifts, then weekly x2 weeks on varying shifts, and monthly x 2. Results will be reported to QA committee for review and analysis. **Date Completed:** **The facility will be in and maintain Compliance with the requirement as of 8/25/15**	08/25/15

(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and facility document review, the facility staff failed to follow infection control practices during ice distribution and handwashing. Ice was distributed to residents in an unsanitary manner and improper handwashing was observed during a medication pass observation.

The findings include:

1. Ice was distributed to residents in an unsanitary manner.

On 7/14/15 at 3:25 p.m. certified nurses' aide (CNA) #1 and #4 were observed filling residents' water pitchers with ice outside rooms 182 and 184. The CNAs retrieved the pitchers from

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resident rooms and held the pitchers over the clean ice supply while filling them with ice. The CNAs at times touched the water pitchers with the edge of the ice scoop and ice cubes from the filled pitchers fell back into the clean ice supply. CNA #1 and CNA #4 filled four resident pitchers from rooms 182 and 184 holding the pitchers over the clean ice and at times making contact with the scoop to the pitchers. On 7/14/15 at 3:30 p.m. CNA #1 filled the water pitchers on two medication carts with ice from the same ice supply used to fill the residents' water pitchers.

On 7/14/15 at 3:30 p.m. CNA #1 was interviewed about holding the personal resident pitchers over the clean ice supply when filling with new ice. CNA #1 stated, "That's the normal way we do it. I'm not sure. We clean the pitchers three times per week."

On 7/14/15 at 3:45 p.m. the registered nurse (RN #3) working on the unit was interviewed about the residents' personal water pitchers held over the clean ice when refilling. RN #3 stated, "They (CNAs) are not supposed to hold the pitchers over the ice." RN #3 stated the pitchers were supposed to be held to the side of the cooler when refilling and the scoop was not supposed to contact the pitchers.

On 7/15/15 at 9:00 a.m. the director of nursing (DON) was interviewed about ice distribution. The DON stated resident mugs/pitchers were not to be held over the ice chest when refilling. The DON stated, "They (CNAs) may have been trying not to spill ice. They were not thinking about the infection control aspect."

The facility's policy titled Handling Ice and Ice

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495360	A. BUILDING _____ B. WING _____	07/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WOODLANDS HEALTH AND REHAB CENTER	1000 FAIRVIEW HEIGHTS CLIFTON FORGE, VA 24422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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Scoops (revised 1/2015) stated, "Ice and ice scoops are handled in a way to prevent contamination of ice."

These findings were reviewed with the administrator and director of nursing during a review meeting on 7/15/15 at 11:50 a.m.

2. During a medication pass observation a nurse failed to follow infection control practices for handwashing. Registered nurse (RN) #2 did not remove a wrist brace on her left hand prior to handwashing resulting in no hand hygiene performed to the left palm, thumb and wrist area.

On 7/15/15 at 7:40 a.m. RN #2 was observed administering medications to Resident #6. RN #2 had a soft splint/brace in place on her left wrist covering part of her palm, the area around the base of her left thumb and her wrist and lower forearm. After preparing and administering oral medications to Resident #6, RN #2 washed her hands in the room sink. RN #2 washed her hands with the splint in place. During RN #2's handwashing, there was no contact with water or soap to the areas covered by the splint. RN #2 only washed the fingers on her left hand.

On 7/15/15 at 8:00 a.m. RN #2 was interviewed about her handwashing technique with the wrist splint/brace in place. RN #2 stated, "I just had sticky Prostat on my fingers so I was washing that off." RN #2 stated she was able to take the brace off if needed but she had difficulty fitting gloves over the brace. RN #2 stated, "If I was doing a dressing change I would take it (brace) off."

On 7/15/15 at 9:00 a.m. the director of nursing (DON) was interviewed about the incomplete

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handwashing by RN #2 during the medication pass. The DON stated, "She (RN #2) should have taken off the brace to perform proper hand hygiene."

The facility's infection control policy titled Procedure for Handwashing (revised 4/2005) stated, "...Wet hands with water...Apply 1 squirt of soap. Using friction, rub hands together, cleaning under nails and between fingers thoroughly. Wash up to your wrist as well. Do this for at least 10-15 seconds...Rinse hands well without touching the inside of the sink or the faucet...Leave water running...Dry hands well. When finished, turn off faucet with a clean paper towel. Discard the towel..."

These findings were reviewed with the administrator and director of nursing during a review meeting on 7/15/15 at 4:50 p.m.